Kairos Chiropractic
PATIENT INTAKE FORM

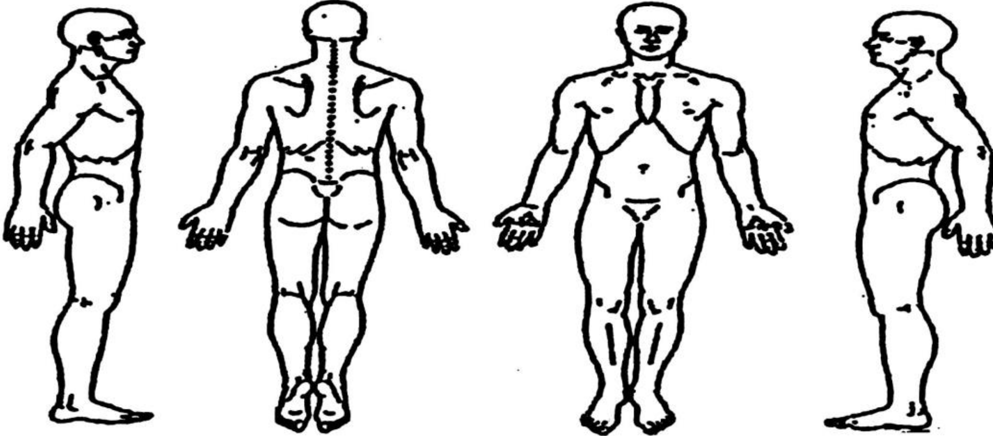
Patient Name: ______________________________ Date: _______________

1. Are you here because you were injured while working, in a motor collision, or in another accident?

____

What is the main reason for your visit? ____

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

Constantly (76-100% of the time) Occasionally (26-50% of the time)
Frequently (51-75% of the time) Intermittently (1-25% of the time)

4. How would you describe the type of pain?

Sharp	Numb
Dull	Tingly
Diffuse	Sharp with motion
Achy	Shooting with motion
Burning	Stabbing with motion
Shooting	Electric like with motion
Stiff	Other:___________________

5. How are your symptoms changing with time?

Getting Worse Staying the Same Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

Not at all A little bit Moderately Quite a bit Extremely

8. How much has the problem interfered with your social activities?

Not at all A little bit Moderately Quite a bit Extremely

9. Who else have you seen for your problem?

Chiropractor	Neurologist	Primary Care Physician
ER physician	Orthopedist	Other:_____________
Massage Therapist	Physical Therapist	No one

10. How long have you had this problem? _____________ days/weeks/months/years

11. How do you think your problem began?

____

12. Do you consider this problem to be severe?

Yes Yes, at times No

13. What aggravates your problem?

____

Kairos Chiropractic

14. What concerns you the most about your problem; what does it prevent you from doing?
____

15. What is your: Height___________ Weight _____________ Date of Birth ___________
Occupation ____

16. How would you rate your overall Health?
Excellent Very Good Good Fair Poor

17. What type of exercise do you do?
Stenuous Moderate Light None

18. Indicate if you have any immediate family members with any of the following:

Rheumatoid Arthritis	Diabetes	Lupus
Heart Problems	Cancer	ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past Present
- □ Headaches
- □ Neck Pain
- □ Upper Back Pain
- □ Mid Back Pain
- □ Low Back Pain
- □ Shoulder Pain
- □ Elbow/Upper Arm Pain
- □ Wrist Pain
- □ Hand Pain
- □ Hip Pain
- □ Upper Leg Pain
- □ Knee Pain
- □ Ankle/Foot Pain
- □ Jaw Pain
- □ Joint Pain/Stiffness
- □ Arthritis
- □ Rheumatoid Arthritis
- □ Cancer
- □ Tumor
- □ Asthma
- □ Chronic Sinusitis
- □ Other:____________________________

Past Present
- □ High Blood Pressure
- □ Heart Attack
- □ Chest Pains
- □ Stroke
- □ Angina
- □ Kidney Stones
- □ Kidney Disorders
- □ Bladder Infection
- □ Painful Urination
- □ Loss of Bladder Control
- □ Prostate Problems
- □ Abnormal Weight Gain/Loss
- □ Loss of Appetite
- □ Abdominal Pain
- □ Ulcer
- □ Hepatitis
- □ Liver/Gall Bladder Disorder
- □ General Fatigue
- □ Muscular Incoordination
- □ Visual Disturbances
- □ Dizziness

Past Present
- □ Diabetes
- □ Excessive Thirst
- □ Frequent Urination
- □ Smoking/Tobacco Use
- □ Drug/Alcohol Dependance
- □ Allergies
- □ Depression
- □ Systemic Lupus
- □ Epilepsy
- □ □ Dermatitis/Eczema/Rash
- □ □ HIV/AIDS

For Females Only
- □ Birth Control Pills
- □ Hormonal Replacement
- □ Pregnancy

20. List all prescription medications you are currently taking:
____

21. List all of the over-the-counter medications you are currently taking:
____

22. List all surgical procedures you have had:
____

23. What activities do you do at work?

Sit:	Most of the day	Half the day	A little of the day
Stand:	Most of the day	Half the day	A little of the day
Computer work:	Most of the day	Half the day	A little of the day
On the phone:	Most of the day	Half of the day	A little of the day

24. What activities do you do outside of work?
____

25. Have you ever been hospitalized? No Yes
if yes, why ____

26. Have you had significant past trauma? No Yes

27. Anything else pertinent to your visit today?____

Patient Signature___________________________________ **Date:**____________________

215 S. Denton Tap Road, Suite 285 Coppell, TX 75019 972 304 3900